STATE OF LOUISIANA

CITATION
42 CFR 431.11

INTRODUCTION
The Department of Health and Hospitals (DHH - hereinafter sometimes referred to as the Department) is the State agency designated by state law to administer the Title XIX (Medicaid) State Plan. The Bureau of Health Services Financing (BHSF - hereinafter sometimes referred to as the Bureau) is the unit within the Department responsible for the operation and management of Louisiana's Medical Assistance Program which is known as the Medicaid Program. Specific functions performed by the Bureau of Health Services Financing relative to program eligibility include the following: maintaining parish or regional staff including staff positioned in the acute care hospitals operated by the State making determinations of eligibility of Medicaid applicants and persons due for redeterminations of eligibility; managing the recipient eligibility file; issuing the monthly Medicaid eligibility cards through the Medicaid fiscal intermediary; soliciting and enrolling of qualified providers and public agencies as Application Centers (AC) to provide intake and outreach to prospective eligibles; and providing training in eligibility requirements/regulations for the Bureau and AC staff.

The Bureau of Health Services Financing provides information upon request to facilities/agencies interested in serving as an AC. The Bureau has established the standards of participation. It has developed the required training/certification program. It has developed an Application Center Handbook outlining major administrative and regulatory provisions governing outreach and intake under Medicaid. The Bureau requires completion of a written contractual agreement specifying the responsibilities of the DHH - BHSF and the institution/agency serving as the AC.

The Bureau has determined that in order to institute an effective statewide outreach system for potential Medicaid applicants, a variety of qualified health and social agencies are needed to serve as ACs. In addition, the Bureau has developed appropriate guidelines to assure compliance with federal and state regulations governing outreach and intake efforts. These objectives of availability and regulatory compliance are included in the following standards.

A. STANDARDS FOR PARTICIPATION

In order to participate as an AC, the provider applicant must not have been suspended or excluded from participating in the Medicaid program and must meet one of the following definitions:

1. An institutional provider of Medicaid services (e.g. hospitals, long term care facilities).

2. A state program which provides health or social services to the local population which is staffed by state employees (e.g. Parish Health Units, Mental Health Units).

3. A federally funded program which provides health or social services to the local population authorized under Section 329, 330 and 340 of the Public Health Services Act (e.g. FQHC).

4. A parish, state, or federally sponsored program providing services to the community; has designated business offices with established hours of operation; a full-time staff who works with the general public performing the normal duties of the program; and the endorsement and recommendation of local government for certification training (e.g. Headstart).

5. A private program providing health or social services to an identifiable segment of the local community; designated business offices with established hours of operation; a full-time staff who works with the general public in performing the duties of the program; and the endorsement and recommendation of local government for certification training (e.g. V.O.A., Catholic Community Services).

6. Home Health agencies or other agencies/programs specifically approved by the Bureau of Health Services Financing.

B. REQUIRED TRAINING

Prospective AC Managers are required to attend a management orientation after which referred qualified personnel must successfully complete the Medicaid AC Representative training. The Representative training includes an overview of the Medicaid programs available, the eligibility factors considered in the application process, pre-certification responsibilities, and a detailed review of the comprehensive application process.

C. WRITTEN AGREEMENT: DHH - BHSF AND APPLICATION CENTER

The rights and responsibilities of DHH - BHSF and the AC are outlined in the written agreement between the BHSF and the Application Center.

1. The Department of Health and Hospitals, Bureau of Health Services Financing, will assume responsibility for the administration and oversight of the AC's participation in the Medicaid Program. The Department of Health and Hospitals agrees to assist ACs in the following ways:

   a. Each potential AC is furnished with information on the program, the Standards for Participation and an agreement. Management staff is required to attend an AC Management Orientation.

   b. BHSF provides for Medicaid AC Representative training for approved AC staff after the AC has completed the requirements in Item 1.a. above.

   c. BHSF awards the AC Representative a certification letter, certificate and an AC Handbook to those approved AC staff who have attended AC Representative training and passed the required test.

   d. DHH/BHSF will monitor AC operations to assure quality service is being offered to applicants.

   e. DHH/BHSF will review applications to ensure that the following conditions for reimbursement are met: 1) the application is complete; 2) the application is sent to the appropriate Regional/Parish Medicaid office; and 3) the application is forwarded within established time frames as set forth in the AC Handbook.

   f. DHH/BHSF will determine whether invoices are for payable services and process appropriately.

2. AGREEMENT/RESPONSIBILITIES - The agreement must be signed by the administrator or designee who has been duly authorized by the corporation/partnership to act on its behalf. If the AC is a corporation, the authorization must be evidenced by a corporate resolution which authorizes a particular person to sign on behalf of the corporation. If the AC is a partnership,

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the authorization must be evidenced by the Articles of Partnership. Once the duly authorized representative of the AC signs, the AC and its employees are bound by the agreement. The signature of the duly authorized representative of the AC on the agreement form serves as the facility's agreement to abide by all policies and that, to the best of his/her knowledge, the information contained on the application form is true, accurate and complete. Once the agreement between the DHH and the AC is completed, the AC:

a. understands that their facility must qualify based upon the Standards for Participation. The duly authorized representative of the AC must sign the Agreement and must attend the AC Management Orientation;

b. understands that it has the right to terminate its agreement for any reason in writing with thirty (30) days prior notice to DHH. The AC understands that DHH has the right to terminate the agreement with ten (10) days notice for violation of any of the stated agreements and responsibilities as set forth in the agreement. The agency reserves the right to institute a thirty (30) day period of corrective action in coordination with the AC;

c. agrees to maintain such records as outlined in the AC Handbook. These records are to be provided upon request by the State Medicaid Agency, the Secretary of the Department of Health and Hospitals, the Medicaid Fraud Control Unit, or the U. S. Department of Health and Human Services. These records must be maintained for a minimum of three years from the date of service;

d. understands that, as a condition of enrollment and participation, it is responsible for assuring and monitoring confidentiality (including, but not limited to, the fact that the intake or application unit of the provider entity is prohibited under the rules of confidentiality from sharing any information pertaining to the recipient with any other unit of the provider entity), non-discrimination and quality standards and adhering to Federal and State requirements relative thereto;

e. must undergo periodic monitoring by State and/or Federal officials without prior notice and agree that State and/or Federal officials will have access to the premises to inspect and evaluate work being performed. The AC understands that decertification may result if, according to the

determination of the State or Federal agency, non-conformance with policies is found;

f. agrees that only persons who have successfully completed certification training with a passing grade will be allowed to complete Medicaid applications and agrees that any change in certified staff will be reported to DHH within ten (10) days to be recorded in the AC profile. The AC shall keep a copy on file of each employee certification document. Replacement staff must be trained and certified prior to completing applications;

g. understands that participation is required in follow-up training provided as specified by BHSF;

h. understands that the Medicaid AC Handbook will be furnished to the facility at no cost and understands and agrees to comply with the provisions of the Medicaid AC Handbook. The AC will be responsible for maintaining and updating this handbook as revisions are issued;

i. understands that application packets will be distributed by DHH. It is the responsibility of the AC to maintain an Applications Transmittal Log. Transmittal logs will be used for submitting applications, invoicing, monitoring and review purposes.

j. must forward all completed applications to DHH within established time frames, as stated by the AC Agreement form. All applications must be accompanied by a transmittal log for proper documentation;

k. must adhere to published regulations from the Department and the Bureau of Health Services Financing governing its participation as an AC.

Either party may terminate the agreement in writing. Thirty (30) days prior notice is required for an AC to terminate participation. Ten (10) days prior notice is required for DHH to terminate participation by an institution/agency.

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D. MEDICAID ELIGIBILITY DETERMINATION BY THE DEPARTMENT OF SOCIAL SERVICES

Within the Department of Social Services, the Office of Family Support and the Office of Community Services have a role in the eligibility determination process for Medicaid. The Office of Family Support administered the Title IV-A program in which persons who were certified for AFDC automatically became eligible for Medicaid. The Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193) eliminated the AFDC program and replaced it with a block grant program for temporary assistance for needy families (TANF). This law also established a new medicaid eligibility group for low-income families with children. The Office of Family Support determines eligibility for low income families as described in Att.2.2-A, p.1 and Att.2.6-A, Supplement 12.

The Office of Community Services determines Medicaid eligibility for those children in the care and custody of the State's foster care program.

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